SAGE MEDICINE

MEDICAL RECORDS RELEASE FORM

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Patient name: _____ DOB: _____

Patient address: _____

City/State/Zip: _____ Phone:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the entity listed below.

For the period of 9-1-2019 to Current

I hereby authorize the release of information:

From:

UT Health Medical Arts & Research Center
Family Medicine / Primary Care
MARC – Mail Code 8303
8300 Floyd Curl Drive, 1st Floor
San Antonio, TX 78229
Phone: (210) 450-9760
Fax: (210) 450-6058

TO:

Carmen Cawley, MD
Sage Medicine, PA
4315 Moonlight Way
Suite 102
San Antonio, TX 78230
Phone: (210) 510-2141
Fax: (210) 510-2135

Information to be released:

☑ All items indicated below:

☐ Progress Notes / Consultation Notes (1 year only)
☐ Medical Summary
☐ Pathology Reports
☐ Immunization Records
☐ Endoscopy Reports
☐ Lab Reports
☐ Radiology Reports
☐ Cardiac Reports
☐ Pulmonary Reports
☐ Operative Reports
☐ ER Records: Date:_____
☐ Hospital Records: Date:_____
☐ Other: _____

Please respond to this request within a reasonable time to avoid delays in patient care.

_____ _____

Patient, guardian, or legal representative (signature) **Date:**

Office use only:
Date faxed: _____ Date mailed: _____ Initials: _____